RE: _____

DATE REC'D: _____

LTC: _____
(for office use only)

D'Youville
LIFE & WELLNESS COMMUNITY

D'Youville Senior Care

APPLICATION FOR ADMISSION

APPLICATION FOR ADMISSION

D'Youville Senior Care

Patient Name: _____ Date: _____

Address: _____ Zip: _____ Phone: _____

Current Location: Home Hospital Other _____ Date of Admission: _____

If Hospital, Case Manager's Name: _____

Inquiry made by: _____ Phone: _____

DOB: _____ Sex: _____M _____F Birthdate: _____ Religion: _____

Marital Status: M S W D Parish/Congregation _____

Former Occupation: _____ How did you hear about us? _____

Are you seeking: Long Term Care Short Term Care

Contact (1) Name: _____ Relationship: _____

Address: _____ Zip _____

Home Phone: _____ Email:_____ Work Phone: _____

Contact (2) Name: _____ Relationship: _____

Address: _____ Zip _____

Home Phone: _____Email:_____ Work Phone: _____

Name of Health Care Proxy Agent: _____ Power of Attorney _____

Conservator _____ Guardian _____

Method of Payment: Private ____ Medicare ____ Medicaid ____ Other _____

Social Security # _____ Other _____

Medicare # _____ Part A ___Yes ___No Part B ___Yes ___ No

Other Insurance ___Yes ___No Company: _____ Policy #: _____

Phone # _____ Type of Coverage _____

Patient's Diagnosis / Medical Problems: _____

_____

_____

Please list patient's medications: _____

_____

_____

Patient's Primary Physician: _____ Phone: _____

PATIENT CARE INFORMATION:

Does patient feed self? _____

Does patient walk? _____ Independent _____ Assist _____

Walker _____ Cane _____ Not at all _____

Does patient need assist with the following: Bathing _____

Dressing _____ Toileting _____ Transfers _____

Is patient continent? Bladder _____ Bowel _____

Describe patient's skin condition

_____

Any open areas on skin: _____

Does patient have any communicable diseases? _____

_____

Does patient have any diet restrictions or special preferences? _____

_____

Describe patient's vision and hearing: _____

Describe patient's speech: _____

Does patient have any sleep disturbance? _____

Does patient have any problem with pain? _____

Is patient alert: _____ Oriented to person _____ Place _____ Time _____

Is patient aware of request for placement: _____

Behavior

Withdrawn _____ Noisy _____ Cooperative _____ Anxious _____

Agitated _____ Strike out at others: _____ Depressed _____

Does patient have any history of emotional/mental disorders? _____

_____

_____

Describe patient's daily routine:

_____

_____

NAME OF APPLICANT SEEKING ADMISSION _____

FINANCIAL RESOURCES:

TOTAL PENSION AMOUNT (PER MONTH) $ _____

SOCIAL SECURITY AMOUNT (PER MONTH) $_____

OTHER INCOME (PER MONTH) $_____

REAL ESTATE: DESCRIPTION AND ADDRESS OF ANY REAL ESTATE OWNED IN THE LAST 5 YEARS:

_____

APPROXIMATE VALUE IF CURRENTLY OWNED: _____

MORTGAGE BALANCE: _____

NAME OF PERSON(S) ON OWNERSHIP PAPERS:

_____

IS THERE RENTAL INCOME? _____ MONTHLY RENT_____

PLEASE LIST BANK/INVESTMENT/BROKERAGE ACCOUNTS:

1._____ BALANCE $_____

2._____ BALANCE $_____

3._____ BALANCE $_____

4._____ BALANCE $_____

IN THE PAST 60 MONTHS HAS THERE BEEN ANY TRANSFER, CHANGE OF OWNERSHIP OF ANY REAL ESTATE, INCLUDING CREATING A LIFE ESTATE, EVEN IF THE LIFE ESTATE WAS PURCHASED IN ANOTHER PERSON'S RESIDENCE?

YES_____ NO_____

IF YOU PURCHASED A LIFE ESTATE IN ANOTHER PERSON'S HOME, DID YOU LIVE IN THE HOME FOR AT LEAST ONE YEAR AFTER YOU PURCHASED THE LIFE ESTATE?
YES____NO____

DID YOU, YOUR SPOUSE, OR SOMEONE ON YOUR BEHALF ADD ANOTHER NAME TO THE DEED OF ANY PROPERTY YOU OWN? YES_____NO_____

DID YOU, YOUR SPOUSE, OR SOMEONE ON YOUR BEHALF PURCHASE OR IN ANY WAY CHANGE AN ANNUITY? YES_____NO_____

FINANCIALLY RESPONSIBLE PERSON:

NAME:_____

ADDRESS:_____

TELEHONE:_____EMAIL: _____

RELATIONSHIP TO APPLICANT_____

*PLEASE PROVIDE A COPY OF POWER OF ATTORNEY, GUARDIANSHIP APPOINTMENT, AND HEALTH CARE PROXY IF APPLICABLE

NAME AND ADDRESS OF ATTORNEY HANDLING AFFAIRS IF APPLICABLE:

_____

PLEASE DISCLOSE ANY ADMISSIONS/CONFINEMENTS TO ANY OTHER HEALTHCARE FACILITIES IN THE PAST 12 MONTHS:

FACILITY NAME: _____ DATES: _____

FACILITY NAME: _____ DATES: _____

*** PLEASE PROVIDE COPIES OF INSURANCE CARDS AND SUPPORT FOR THE FINANCIAL RESOURCES LISTED. COMPLETED APPLICATIONS MUST INCLUDE POWER OF ATTORNEY, GUARDIANSHIP APPOINTMENT AND/OR HEALTH CARE PROXY IF APPLICABLE. PLEASE SEND TO:**

D'YOUVILLE SENIOR CARE
981 VARNUM AVENUE
LOWELL, MA 01854
ATTN: ADMISSIONS
978-569-1000; FAX: 978-349-2062

SIGNATURE _____ RELATIONSHIP _____

DATE _____

D'YOUVILLE SENIOR CARE DOES NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, NATIONAL ORIGINS, HANDICAP OR AGE IN OUR ADMISSION POLICY. THIS IS IN ACCORDANCE WITH LAW AND REGULATIONS:

TITLE VI OF THE CIVIL RIGHT ACT 1984 45 CFR PART 80
SECTION 504 OF THE REHAB ACT 1973 45 CFT PART 84
AGE DISCRIMINATION ACT 1975 45 CFR PART 9